CONFIDENTIAL

Children's Group Home (Level A) and Therapeutic Group Home (Level B) Prior Authorization Request Form

KePRO & DMAS now require that any Medicaid Provider submitting Prior Authorization Requests using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide a 9 digit Zip code. If you do not know your 9 digit Zip code, please visit: http://zip4.usps.com/zip4/welcome.jsp

Fax: 1-877-OKBYFAX (877-652-9329) Phone: 1-888-827-2884

☐ **Initial Review** ☐ **Continued Stay Review** ☐ **Retro Authorization** ☐ **Transfer** ☐ **Change Request**

1) ☐ **CSA Modifier HW** **Locality Code:** ☐ **Non-CSA Modifier HK**	**2) Service Type:** ☐ **Level A (0752)** ☐ **Level B (0753)**	**3) Requested Start Date:** / / **Admission Date:** / /	**4) Expected Discharge Date:** / /
5) Enrollee Last Name:	**6) Enrollee First Name:**	**7) Enrollee Medicaid ID #:**	
8) Date of Birth(mm/dd/yyyy)**:** / /	**9) Gender:** ☐ Male ☐ Female	**10) Provider Name:** **11) Provider NPI/API Number:**	**12) Provider Address (including required 9-digit Zip Code):**
13) Contact Person:	**14) Provider Phone Number:**	**15) Provider Fax Number:**	

16) DSM IV Diagnostic Codes: **Axis I** _____ **Axis II** _____ **Axis III** _____	**Axis IV** _____ **Axis V (GAF):** **Current:** **Highest level in past 6 months:**

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17) Enrollee Last Name:	18) Enrollee First Name:	19) Enrollee Medicaid ID Number:

20) INITIAL REVIEW

Initial Plan of Care (IPC) with all the required elements completed, signed, and dated within 3 days of admission *(signed by QMHP for Level A; LMHP for Level B)*? ☐ **Yes** ☐ **No** **Date of IPC:**

For CSA:

a. CON signed and dated by the physician and 3 members of the team? ☐ **Yes** ☐ **No** **Date of CON:**

b. CAFAS documenting at least 2 moderate impairments and current within 90 days of admission? ☐ **Yes** ☐ **No** **Date of CAFAS:**

OR

c. CANS documenting at least two Level 2 or 3 impairments under Child Behavioral/Emotional Needs and/or Child Risk Behaviors completed? ☐ **Yes** ☐ **No**
Date of CANS .

For Non-CSA: (This category includes adoption subsidy cases)

a. Certification of services completed, signed and dated by physician and LMHP? ☐ **Yes** ☐ **No** **Date of Certification:**

b. Assessment documenting 2 moderate impairments completed by PCP or EPSDT physician and LMHP? ☐ **Yes** ☐ **No**
Date of Assessment:

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21) CONCURRENT REVIEW

a. Comprehensive Individual Plan of Care (CIPOC) completed within 30 days of admission with dated signature *(signed by QMHP and Program Director for Level A; LMHP for Level B)*? ☐ **Yes** ☐ **No** **Date of CIPOC:**

b. CIPOC updated every 30 days with dated signature *(signed by QMHP for Level A; LMHP for Level B)*? ☐ **Yes** ☐ **No**
Date of CIPOC update:

c. Weekly individual psychotherapy provided by LMHP? ☐ **Yes** ☐ **No**

d. Seven (7) psycho educational activities provided each week? ☐ **Yes** ☐ **No**

e. Group psychotherapy provided by LMHP *(Level B only)*? ☐ **Yes** ☐ **No**

If NO to any of the above, please explain:

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22. Severity of Illness / Current Behaviors: For the Initial Review, provide a narrative of the behaviors exhibited by the client over the past 30 days that warrant the requested level of care (please identify frequency, intensity, and duration of behavior). Describe failed treatments within the past month. Describe support system. For continued stay, this information should come from the most current 30 day progress report. Describe functioning (peer relations, school behaviors, self-care) in past month.

DMAS 365 Level A & Level B RESIDENTIAL TREATMENT CARE ELECTRONIC FAX FORM INSTRUCTIONS

Web Resources: **www.dmas.kepro.org**
www.dmas.virginia.gov

This FAX submission form is required for Level A & Level B Residential Treatment Care (RTC) prior authorization review.

Please ensure that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via fax for additional information.

If KePRO determines that your request meets appropriate review guidelines, the request will be "tentatively approved" and transmitted to First Health Services (FHS) for final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to you via the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours of the decision.

- **Please check the appropriate type of review (INITIAL, if this is a first time request; CONTINUED STAY, if services are continuing;, RETRO, if Medicaid eligible after services begun, or TRANSFER, if services were transferred from another provider)**

  1. **Please place an X on either CSA Modifier or Non-CSA Modifier and enter the 3-digit Locality Code**
     - **If this is an adoption subsidy case, it is a Non-CSA case.**
     - **Enter the 3-digit Locality Code for CSA request only**
       - The ***Locality Code*** reflects the locality that has fiscal responsibility for the Medicaid recipient
  2. **Please mark with an X the appropriate type of service (Level A or Level B)**
  3. **Requested Start Date/Admission Date**
     - Please enter the appropriate dates
  4. **Expected Discharge Date**
     - Please enter the expected discharge date
  5. **Enrollee Last Name**
     - Enter the enrollee's last name exactly as it appears on the Medicaid card
  6. **Enrollee First Name**
     - Enter the enrollee's first name exactly as it appears on the Medicaid card
  7. **Enrollee Medicaid ID Number**
     - Please ensure that the enrollee's Medicaid number is valid and contains 12 digits *(this is the Provider's responsibility)*
  8. **Date of Birth**
     - Enter the enrollee's date of birth in the MM / DD / YYYY format (for example, 02/25/2008)
  9. **Gender**
     - Please mark the appropriate gender of the recipient
  10. **Provider Name**

- Enter the requesting provider's name

11. Provider NPI/API Number

- Enter the Provider NPI/API number. A 10 digit number is used for the National Provider Identifier or Atypical Provider Identifier

12. Provider Address (including required 9-digit Zip Code)

- Enter the provider's service address
- **9 Digit Zip Code *(Required)***: Providers must enter their 9 digit Zip code to ensure that their correct location is identified for the National Provider Identifier (NPI) number

13. Contact Person

- Enter the primary contact for the requesting provider

14. Provider Phone Number

- Enter the phone number of the requesting provider

15. Provider Fax Number

- Enter the fax number of the requesting provider

16. DSM-IV Codes

- Enter the appropriate DSM-IV diagnosis on all 5 Axes

17. Enrollee Last Name

- Please re-enter the enrollee's last name on each page of your submission

18. Enrollee First Name

- Please re-enter the enrollee's first name on each page of your submission

19. Enrollee Medicaid ID Number

- Please re-enter the enrollee's valid 12 digit Medicaid number on each page of your submission

20. Initial Review

- Please answer the questions and explain any "NO" answers at the bottom of the section
- Provide information regarding the completion of either the CAFAS or CANS.

21. Concurrent Review

- Please answer the questions and explain any "NO" answers at the bottom of the section

22. Additional Information

- Enter Severity of Illness and Intensity of Services from McKesson InterQual ® Level of Care, Behavioral Health Criteria, Residential & Community Based Treatment 2008 and the Community Mental Health Rehabilitative Services Manual. Include any additional comments in the spaces provided

Virginia Locality Codes

CODE	NAME	CODE	NAME	CODE	NAME
001	Accomack	075	Goochland	153	Prince William
003	Albemarle	077	Grayson	155	Pulaski
005	Alleghany	079	Greene	157	Rappahannock
007	Amelia	081	Greensville	159	Richmond
009	Amherst	083	Halifax	161	Roanoke
011	Appomattox	085	Hanover	163	Rockbridge
013	Arlington	087	Henrico	165	Rockingham
015	Augusta	089	Henry	167	Russell
017	Bath	091	Highland	169	Scott
019	Bedford	093	Isle of Wight	171	Shenandoah
021	Bland	095	James City	173	Smyth
023	Botetourt	097	King and Queen	175	Southampton
025	Brunswick	099	King George	177	Spotsylvania
027	Buchanan	101	King William	179	Stafford
029	Buckingham	103	Lancaster	181	Surry
031	Campbell	105	Lee	183	Sussex
033	Caroline	107	Loudoun	185	Tazewell
035	Carroll	109	Louisa	187	Warren
036*	Charles City	111	Lunenburg	191	Washington
037*	Charlotte	113	Madison	193	Westmoreland
041	Chesterfield	115	Mathews	195	Wise
043	Clarke	117	Mecklenburg	197	Wythe
045	Craig	119	Middlesex	199	York
047	Culpeper	121	Montgomery		
049	Cumberland	125	Nelson		
051	Dickenson	127	New Kent		
053	Dinwiddie	131	Northampton		
057	Essex	133	Northumberland		
059	Fairfax	135	Nottoway		
061	Fauquier	137	Orange		
063	Floyd	139	Page		
065	Fluvanna	141	Patrick		
067	Franklin	143	Pittsylvania		
069	Frederick	145	Powhatan		
071	Giles	147	Prince Edward		
073	Gloucester	149	Prince George		

INDEPENDENT CITIES of Virginia

CODE	NAME	CODE	NAME
510	Alexandria (city)	683	Manassas (city)
515	Bedford (city)	685	Manassas Park (city)
520	Bristol (city)	690	Martinsville (city)
530	Buena Vista (city)	700	Newport News (city)

540	Charlottesville (city)	710	Norfolk (city)
550	Chesapeake (city)	720	Norton (city)
560	Clifton Forge (city)	730	Petersburg (city)
570	Colonial Heights (city)	735	Poquoson (city)
580	Covington (city)	740	Portsmouth (city)
590	Danville (city)	750	Radford (city)
595	Emporia (city)	760	Richmond (city)
600	Fairfax (city)	770	Roanoke (city)
610	Falls Church (city)	775	Salem (city)
620	Franklin (city)	780	South Boston (city)
630	Fredericksburg (city)	790	Staunton (city)
640	Galax (city)	800	Suffolk (city)
650	Hampton (city)	810	Virginia Beach (city)
660	Harrisonburg (city)	820	Waynesboro (city)
670	Hopewell (city)	830	Williamsburg (city)
678	Lexington (city)	840	Winchester (city)
680	Lynchburg (city)		